APCD Daily TAG Call – Meeting Highlights (January 7th – 14th)

Friday, January 7th TAG call highlights

Purpose of the daily TAG calls – Young J. provided introductory comments referencing the email invitation for the TAG calls scheduled daily from Friday, January 7th through Friday, January 14th. He stated the Division's goal is to address common submission issues that have been observed across all carriers and provide timely feedback that will benefit all payers in preparation for the January 31st submission deadline. In addition, the Division's liaisons will continue to reach out to payers to address specific drop file issues and variance application request. The Division encourages payers to submit questions to Young Joo (young.joo@state.ma.us) so the Division can provide guidance as quickly as possible.

1. Submitting test files before submitting production files – Young J. referenced the email sent to payers on December 28th which provided test file submission guidance. In order to maximize payer and Division resources to ensure file submissions with the highest quality data, the Division provided guidance with recommendations for submitting test files before production files are submitted. The Division encourages payers to submit one-month of data for each file type to help manage the content analysis and updates to resolve any issues.

   (Copied from the December 28th email)
   Test File Submission Guidance
   PRODUCTION FILES should NOT be submitted until the following items have been completed:
   1. Submit test files for one (1) month of data for each file type
   2. Use TEST file indicator for test file submissions
   3. Pass file structure
   4. Receive threshold/edit reports
   5. Division analysts conduct analysis on the content of the files
   6. Payers receive critical feedback to fix any identified issues

2. Resolving drop files – 4 common issues:
   - Mismatch on Year/Month – selecting different year and/or month in SENDS+ from what is in header/trailer/body
   - Mismatch on file type – selecting one file type (pharmacy) in SENDS+ and having another (medical) in actual file
   - Populating MHIC ID for Payer field in header/trailer/body rather than Division assigned Org ID (Org ID should be a 3-5 digits but the field length allows for up to 8 characters)
   - Extra field(s) causing drop. An extra asterisk is usually the cause

3. What to put in beginning/end date for Product file? Populate with submission month/year based on when we are expecting that file. Since this is a quarterly file here are examples:
   201012
   201103
   201106
   201109
   201112

4. Fields with "NULL" as acceptable values should not be entered with the literal word NULL but rather should be a null field or left blank.

5. The Division is working on updating the reports for payers to display the sorting of errors by data element.

Monday, January 10th - TAG Call Meeting Notes:

1. General TAG call information – Young J. provided some general administrative information about the daily TAG calls with the following highlights:
    - The Division has reserved the 2pm – 3pm hour each day until Friday, January 14th to convene the Technical Assistance Group conference calls. Generally, the Division will remain on the call for as long as is needed. If the discussion ends before 2:30pm, the Division will remain on the call until 2:30pm and payers should feel free to send questions or comments directly to Young Joo (young.joo@state.ma.us).
    - With the forecasted snow storm on Tuesday evening into Wednesday, if many offices are closed Young Joo will send an email to this group notifying payers of a cancelled TAG call for Wednesday, January 12th. Please feel free to notify Young Joo if your offices will be closed and no one from your team will be able to participate on the call.

2. Member Eligibility File – The Division provided guidance and clarification on the submission of the Member Eligibility file with the following highlights:
    - The initial data submission by January 31, 2011 should include 2 member eligibility files –
        i. The first file should encompass the time period from January 2008 through December 2009
        ii. The second file should encompass the time period from January 2009 through December 2010
    - The monthly data submission beginning in February 2011 should include the rolling 24-month period ending with the previous month (i.e. February 2009 through January 2011)
    - Young J. will include additional information and examples as a follow-up to the Tuesday, January 11th meeting summary.
    - In the meantime, other resources and examples of the Member Eligibility File are also available with the FAQ package (link) also found under USER RESOURCES of the APCD Website (www.mass.gov/dhcfp/apcd)
3. Other issues –
    - The Division is working to fix a bug on SENDS+ that causes the Test Indicator box to be cleared after it has been checked and a file type is chosen
    - The Division will provide payers with a look-up table to reference the Delegated Benefits Administrator fields on the Medical, Pharmacy, and Dental claims files

Tuesday, January 11th TAG call highlights

1) Member Eligibility File discussion – The Division addressed additional questions regarding the member eligibility file submission and has provided the information below (and attached):

   - Submission Guide definition: The Member Eligibility file should be "A complete historical file reporting back on a 24 month rolling base". The 24 month rolling base means that any person having eligibility and MA residence for any period in the prior 24 months will remain in that data file until the 25th month after their eligibility (plan and/or residence eligibility) has lapsed. Each new monthly Eligibility file will have the same members as the prior month, inclusive of any new record updates or new eligible persons – minus any persons whose eligibility or MA residence criteria has lapsed past 24 months.

     Eg) As of January 2011 Member X has been an eligible member for the last 3 years. They moved out of Massachusetts in Feb 2009.

     a. December 2010 Member file – filed in January … Member X appears in file (albeit their State of residence is not MA).

     b. January 2011 Member file – filed in February… Member X appears in file (albeit their State of residence is not MA).

     c. February 2011 Member file – filed in March… Member X no longer appears in the eligibility file because they have lapsed past the 24 month rolling base.

     It is assumed that claims related to these members will contain the address information collected by the Provider at the Date of Service – since the specification indicates the electronic claim as the data source. Consequently paid claims may continue to be sent to the Division after the member no longer lives in Massachusetts, or is otherwise no longer eligible for the carrier's plan – for the time period prior to eligibility termination.

Same information in decision table form:

Eligible	MA Resident	Include in Eligibility File	Filing Month
Y	Y	Y	Jan 09
Y	Y	Y	Feb 09
Y	N	Y	Mar 09
Y	N	Y	A
Y	N	Y	M
Y	N	Y	J
Y	N	Y	J
Y	N	Y	A
Y	N	Y	S
Y	N	Y	O

Y	N	Y	N
Y	N	Y	Dec 09
Y	N	Y	Jan 10
Y	N	Y	F
Y	N	Y	M
Y	N	Y	A
Y	N	Y	M
Y	N	Y	J
Y	N	Y	J
Y	N	Y	A
Y	N	Y	S
Y	N	Y	O
Y	N	Y	N
Y	N	Y	Dec 10
Y	N	Y	Jan 11
Y	N	N	Feb 11
Note: Only the highlighted are required filing months.			

2) Delegated Benefits Administrator fields (Lookup Table) – On a previous call, a payer requested the look-up table for the delegated benefits administrator fields in the medical claims (MC100), dental claims (DC025), and pharmacy claims (PC072) field. The text file (APCD.txt) is attached to this email. *Please contact Young Joo (young.joo@state.ma.us) if you need the file to load the table or if a delegated benefits administrator you are looking for is not listed.

   Additional information about the APCD text file:
   - File format:
     - Text tab delimited
     - Unique on OrgID, sorted by Organization Name
   - Fields:
     - OrgID
     - Organization Name
     - City
   - Selection criteria:
     - Has an APCD filing record for any of the 6 types (Product, Provider, Eligibility, Medical, Pharmacy Dental), or exists in the Division's database classified as a Health Insurance Company, or Third Party Payer – Surcharge.

Wednesday, January 12th TAG call highlights – MEETING CANCELLED due to snowstorm

Thursday, January 13th TAG call highlights

1. Delegated Benefits Administrator – On the TAG call meeting highlights from Tuesday, January 11th, the Division provided a lookup table attachment to submit the delegated benefits administrator fields on the medical claims (MC100), dental claims (DC025), and pharmacy claims (PC072) files. If a payer does not see a specific TPA, PBM, or other entity listed on the file, please contact the Division with the name of the benefits administrator entity with information for a contact person and the Division will provide an OrgID to complete the field.
2. Carrier Specific Lookup Tables – The Division has now confirmed that Carrier Specific Lookup Tables have been loaded into the system and all subsequent edit reports should reflect this update.
3. Voids/Amendments/Replacements – The Division summarized the definitions of voids, amendments, and replacements. Payers should reference the file "Claims Voids and Replacements Versioning Protocol" found in the FAQ package from the Division's APCD website for further guidance including specific examples. The FAQ package is available from the APCD website (www.mass.gov/dhcfp/apcd) under USER RESOURCES (direct link to FAQ package).The document is also copied and pasted below in its entirety:

COPIED FROM THE FAQ PACKAGE FILE -

APCD Versioning – Voiding or Replacing Claims

Claim Voids and Replacements – Versioning Protocol.doc

11/17/2010 – version 3.2

Claim versioning will be triggered by use of the Claim Line Type field. Versioning is indicated by using the claim line type code, in combination with the payer claim control number, line counter, and version number fields. As the table below indicates – code values (V,B) will delete a referenced line previously submitted, and code values (R,A) will replace a referenced line previously submitted .

Claim Line Type Code	*Claim Line Type Description*	*Action/Source*
O	Original	
V	Void	Delete line referenced / Provider
R	Replacement	Replace line referenced / Provider
B	Back Out	Delete line referenced / Payer
A	Amendment	Replace line referenced / Payer

1. **Void** – This is a claim **line** level void. If the claim type is equal to "Void" or "Back Out" (values V, B) then this claim line type will remove the previous referenced claim line, as indicated by payer claim control number, line counter, and version number.

   Eg1 – Dental Claim

DC059 – Claim Line type = V
DC004 - Payer claim control number
DC005 - Line counter
DC005A - Version number.

Eg2 – Medical Claim
MC138 – Claim Line type = V
MC004 - Payer claim control number
MC005 - Line counter
MC005A - Version number.

Eg3 – Pharmacy Claim
PC110 – Claim Line type = V
PC004 - Payer claim control number
PC005 - Line counter
PC005A - Version number.

2. **Replacement** – This is a claim **line** level replacement. If the claim line type is equal to "Replacement" or "Amendment" (values R, A), and the payer claim control number plus line counter is a duplicate value for an existing claim, then this is considered to be a replacement line dependent upon the value in version number. A higher version number value will supersede any previous claim line referenced by the payer claim control number plus line counter.

Eg1 – Dental Claim
DC059 – Claim Line type = O, R or other
DC004 - Payer claim control number
DC005 - Line counter
DC005A - Version number.

Eg2 – Medical Claim
MC138 – Claim Line type = O, R or other
MC004 - Payer claim control number
MC005 - Line counter
MC005A - Version number.

Eg3 – Pharmacy Claim
PC110 – Claim Line type = O, R or other
PC004 - Payer claim control number
PC005 - Line counter
PC005A - Version number.

3. **Alternative –** Using the Former claim number.

Use of "Former Claim Number" (eg. MC139, DC060, PC111) to version claims can **only** be used if approved by DHCFP. Contact Paul Smith or your Carrier specific assigned APCD liaison at DHCFP. Most Carriers should **not** be using this field – see "Claim Voids and Replacements – Versioning Protocol.doc" for the standard protocol.

4. **Resubmission** of an entire months submission file.

   In some cases, an entire month's submission is resubmitted by a carrier. In this case, when a second file for a given time period is received, every claim from the original submission file will be removed from existing downstream datasets and replaced with claims from the new submission.

   This should be a rare occurrence. Replacement of an entire submission is also unnecessary for cumulative files such as Member, Provider and Product files, which in essence replace the prior versions each time.

5. **Frequently Asked Questions.**

   Q1 Should paid amounts be set to negative or zero values on a void claim?
   A1 It is not necessary to set these values to negative. It is also OK if they are negative values already. Both claims (void and original) will be removed from the final analytical dataset created after the versioning process.

   Q2 When multiple versions of a claim line have been submitted, and there is a need to void the entire claim, is it necessary to void each version number?
   A2 **Yes**. Each void only removes a specific line version number. If three line versions were submitted, three line version voids must be submitted to completely remove the original and all replacement claim lines.

6. **Examples.**

   6.a. Single line claim

Payer Claim Control Number - MC004	Line Counter - MC005	Version Number - MC005A	Date Of Service From	Paid Date	Allowed Amount	Paid Amount	Claim Line Type - MC138
12347E005087	0100	1	20070307	20070314	429.30	429.30	O
12347E005087	0100	2	20070307	20080611	-429.30	-429.30	B
12347E005087	0100	3	20070307	20080611	419.30	419.30	A
12347E005087	0100	4	20070307	20080926	-419.30	-419.30	B
12347E005087	0100	5	20070307	20080926	399.30	399.30	A

6.b. Multi line claim

Payer Claim Control Number - MC004	Line Counter - MC005	Version Number - MC005A	Date Of Service From	Paid Date	Allowed Amount	Paid Amount	Claim Line Type - MC138
12347E005087	0100	1	20070307	20070314	429.30	429.30	O
12347E005087	0101	1	20070308	20070314	100	100	O
12347E005087	0100	2	20070307	20080611	-429.30	-429.30	B
12347E005087	0101	2	20070308	20080611	-100	-100	B
12347E005087	0100	3	20070307	20080926	450.00	450.00	A

7. Additional Notes - Supporting metrics from experience.

In rare cases (1/20th of a percent or **3,500** times per month in HCQCC data) a carrier might submit what the Division considers to be a 'true duplicate claim line' – ie the same *Payer Claim Control, Claim Line and Version Number*.* In this instance we currently take the claim that was processed through intake most recently as the highest version of the claim line. If the duplicate occurred within the same submission month we would take the record that was processed later in the file. If this occurred across different monthly submissions, the most recent record would be considered the non-duplicate, and the previous record would be flagged as a duplicate.

Internally, the Division HDAG unit will run monthly quality assurance processes on claims data, independent of any versioning. Although this may in some cases be based on earlier/incomplete versions of a claim and claim line, the expected difference is not statistically significant to the QA metrics we are designing. The QA metrics provide a series or reasonability checks, but are not metrics that are planned for external distribution. As a double check on this theory, we looked at some data.

The HDAG Unit has run query's recently against 4 months of HCQCC Medical Claims data (January-April 2009) and has determined that in a given month only **.05%** of claim lines have the same version number more than once in a given month and are technically, a true duplicate claim; **.85%** of claim lines have more than one version number in a given month; and across a period of 4 months just over 1% (1.08%) of claim lines have more than one version.

Details on the query that produced this number are below. What this shows is that the impact of deciding whether to run QA tests on versioned or un-versioned claims will have an impact of not much more than 1% on any particular metric. However the true impact should be measured across a window of time larger than the study set. For example a full year of data should be versioned after 15 months.

	Line counts	A-Number of unique claims (control numbers + claim line)	% of claims with variance	B-Number of dups (control numbers+ claims line +version)
January	6749130	6678756	1.04%	3778
February	6340681	6292408	0.76%	3627
March	7185656	7131074	0.76%	3474
Jan-Apr	27250854	26957408	1.08%	24793

*Note: In APCD, the field Claim Line Type was added to enhance versioning. If it is the case that a Carrier believes that the combination of *Payer Claim Control, Claim Line and Version Number* does not identify a unique claim line, there may be a versioning issue that needs to be addressed with the division prior to filing.

Friday, January 14th TAG call highlights

1. After introductions, Young J. thanked payers for the active participation on the daily TAG calls in preparation for the initial submission of data by January 31, 2011. He encouraged all payers to continue to submit questions directly to their liaisons and through the variance application review process. In addition, Young J. reiterated the Division's commitment and efforts to support payers throughout the implementation process. In order to further support payers, the Division has requested payers to submit the most recent and updated version of the variance application by the end of next week (Friday, January 21st). The Division provided the following notes as guidance for completing the variance application to further facilitate critical feedback to payers:
    - Variance applications should be completed or updated using the latest version of the form (version 2.1). This version corresponds to the most recent submission guides updated on December 1, 2010.
    - The Division has observed many variance application forms with incomplete fields and explanations for rationale that need more comprehensive descriptions. The Division's goal is to better understand the challenges payers face for specific reporting requirements and a statement such as "Data not available" does not help the Division understand those challenges. Please provide a full explanation for why the data is not available.
    - If a payer has submitted a variance application using a previous version, please re-submit with the most recent updates using version 2.1.
    - If a payer has not received version 2.1 please contact your liaisons immediately.
2. The Division addressed payer specific questions and provided further guidance on the submission of the Member Eligibility file.
    - In addition to the data analysis the Division plans to conduct, Young J. stated that the Division will work with payers to analyze metrics of member migration as a component of understanding how the data affect the submission of the Member Eligibility file.